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Clark County Regional Support Network Policy Statement

Policy No.:	**CM03**
Policy Title:	**Notice of Action**
Effective Date:	**November 1, 2004**

Policy: Clark County Regional Support Network (CCRSN) shall provide both verbal and written Notice of Action to Medicaid enrollees whenever actions occur, as defined in this policy. The Notice of Action shall be issued in a timely manner and written in clear language easily understood by the recipient. Notices of Action shall inform recipients of their rights to appeal or to request an administrative hearing with the Department of Social and Health Services.

CCRSN shall issue a separate Notice of Action letter when requests for mental health services are denied to non-Medicaid consumers. The Notice of Action letter shall be issued in a timely manner and written in clear language easily understood by the recipient. Notices of Action to non-Medicaid consumers shall inform recipients of their rights to file a complaint or grievance with the mental health provider or with CCRSN.

Reference: WAC 388-865, Washington Mental Health Division RSN Interlocal Agreements (Exhibit N: Grievance System Template), CMS Waiver, 42 CFR 438 Subpart F: Grievance System, 42 CFR 431 Subpart E: Fair Hearings, 45 CFR: Health Insurance Portability and Accountability Act (HIPAA), Medical Assistance Administration memorandum #01-03MAA, CCRSN Policy and Procedures: CR03 Consumer Complaints and Grievances, CR06 Consumer Rights to Appeal, CR07 Consumer Rights to an Administrative Hearing, QM05 Element of Care Clinical Guidelines, QM09 Access Standards, CM04 Authorization For Out-patient Services, CM19 Inpatient Services Authorization, CM07-A Access to Care Standards-Adult, and CM08-A Access to Care Standards-Child, CM03 Notice of Action Form-Medicaid, CM03 Form-non-Medicaid

Definitions:

Action means

1. The denial or limited authorization of a requested service, including the type or level of service (for Medicaid enrollees, this includes an intake service);
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service (for Medicaid enrollees, this includes an intake service);
4. The failure to provide services in a timely manner;
5. The failure of CCRSN to dispose of and resolve grievances within 30 days from receipt of the grievance, unless extended by mutual agreement with the consumer;
6. The failure of CCRSN to dispose of and resolve an appeal within 45 days from the receipt of the appeal, unless extended by mutual agreement (for Medicaid enrollees);

Denial means the decision by CCRSN not to authorize covered mental health services that meet medical necessity criteria.

Grievance means an expression of dissatisfaction about any matter other than an action, as "action'" is defined above. The term is also used to refer to the overall system that includes grievances and appeals handled by CCRSN and access to the State administrative hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness.)

Reduction means the decision by CCRSN to decrease a consumer's previously authorized covered Medicaid mental health services described in the CCRSN Element of Care Clinical Guidelines. The decision by a CCRSN contracted provider to decrease or change a covered service in the Individualized Service Plan is not a reduction.

Suspension means the decision by CCRSN to temporarily stop a consumer's previously authorized covered Medicaid mental health services described in the CCRSN Element of Care Clinical Guidelines. The decision by a CCRSN contracted provider to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

Termination means the decision by CCRSN to stop a consumer's previously authorized covered Medicaid mental health services described in the CCRSN Element of Care Clinical Guidelines. The decision by a CCRSN contracted provider to stop or change a covered service is not a termination.

Procedure:

Medicaid Enrollees

1. The Notice of Action letter (Medicaid) must be in writing and must be written in language easily understood by the individual in his or her primary language or in a format that is understandable when the individual has a hearing or visual impairment or developmental disability. Verbal notification will also be given at the time the decision is made.

2. The Notice of Action shall be mailed with receipt confirmation to the mental health consumer or parent or legal guardian when the consumer is under 13 years of age.

3. The Notice must explain the following:
   a. The action CCRSN or its contracted provider has taken or intends to take;
   b. The reasons for the action or intended action;
   c. The consumer's or the CCRSN contracted provider's right to file an appeal with CCRSN;
   d. The consumer's right to request a second opinion;
   e. The consumer's right to request an appeal;
   f. The consumer's right to request a state administrative hearing:
      i. within 20 days of receiving the CCRSN decision (Notice of Action letter)
      ii. if CCRSN did not provide a written response within the allowed timeframes
      iii. any time the consumer believes a Washington Administrative Code has been violated;
   g. The procedures for requesting an appeal or a state administrative hearing.

4. CCRSN must provide notice within the following timeframes:
   a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten days before the effective date of the action or CCRSN may mail a notice not later than the date of action if:
      i. CCRSN has factual information confirming the death of a consumer;
      ii. CCRSN receives a clear written statement signed by the consumer requesting services be discontinued or providing information that requires termination or reduction of services;
      iii. The consumer has been admitted to an institution and is ineligible for further services;
      iv. The consumer has no forwarding address and whereabouts are unknown;
      v. CCRSN establishes the fact that the consumer has been accepted for Medicaid services by another jurisdiction;
      vi. A change in the level of care is prescribed by the consumer's physician;
      vii. The notice involves an adverse determination with regard to preadmission screening requirements;
      viii. The date of the action will occur in less than 10 days.
   b. For denial of payment, at the time of any action affecting the payment;
   c. For standard service authorization decisions that deny or limit services, as expeditiously as the consumer's mental health condition requires and no longer than fourteen (14) days from request for services. If CCRSN extends the timeframe, it shall:
      i. Give the consumer written notice of the reason and inform the consumer of the right to file a grievance if he or she disagrees with the decision;
      ii. Issue and carry out the determination as expeditiously as the consumer's health condition requires and no later than the expiration date of the extension,
   d. CCRSN may shorten the period of advance notice to 5 days before the action if:
      i. CCRSN has facts verified, if possible, through secondary sources indicating probable fraud by the consumer.
   e. For expedited authorizations, CCRSN shall provide notice as expeditiously as the consumer's health condition requires, no later than 3 business days after receipt of the request for services.
   f. For service authorization decisions not reached in accordance within the timeframes established in CCRSN Policy and Procedures on authorization (which constitute a denial and thus an adverse action subject to appeal), CCRSN shall provide notice on the date that the authorization timeframes expire.

5. CCRSN requires its sub-contracted providers to provide verified Medicaid enrollees with an intake upon request and thus this service request is not denied by CCRSN.

Non-Medicaid Consumers

1. A Notice of Action letter (non-Medicaid) shall be mailed to non-Medicaid Clark County residents who request CCRSN-funded services but do not qualify because they do not meet medical necessity criteria for state-funded services provided through CCRSN. The Notice must be in writing and must be written in language easily understood by the individual in his or her primary language or in a format that is understandable when the individual has a hearing or visual impairment or developmental disability.

2. The Notice of Action letter (non-Medicaid) must inform the recipient of their right to file a complaint or grievance with the mental health provider or with CCRSN as well as information about assistance available through the CCRSN Mental Health Ombuds service. The Notice shall also inform recipients of their right to request a State Administrative Hearing at any time they believe a Washington Administrative Code has been violated.

Record-keeping and Reporting Requirements

1. CCRSN shall maintain records of actions as described in the Definitions section of this policy, including denials of requests for mental health services. Information about actions shall be tracked separately for Medicaid and non-Medicaid consumers for reporting purposes and shall include the following data:
   a) The number and type of actions
   b) The timeframes within which notices were issued;
   c) The nature of the decisions;
   d) A summary and analysis of the implications of the data, including what measures may be taken to address undesirable patterns.

2. CCRSN shall report the number of denials of service for Medicaid consumers to the Washington Mental Health Division twice annually, using the reporting form provided in the Pre-paid Inpatient Health Plan contract (Exhibit N-PIHP).

3. CCRSN shall monitor quality of the processes related to actions through:

   a) Oversight that actions occur in compliance with state and federal rules and within required timelines and retaliation does not occur;
   b) Coordination of data collection with the Management Information System;
   c) Review of network provider service request logs through the CCRSN on-site provider monitoring visits to ensure that all Medicaid enrollees requesting an intake receive one;
   d) Aggregation of data and trends reported to the CCRSN Quality Management Committee for the purposes of quality monitoring and service improvement on a quarterly basis.

Approved By: Michael Piper CD Date: 11-27-05

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Clark County
Department of Community Services